Exhibit 7

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

ANTHONY DeFRANCO, **Plaintiff,** **V.** **SUPERINTENDENT WILLIAM WOLF; STEVE REILLY; DENESE BRUNNER; MANAGER ROD SHOWERS; CASE MANAGER GECAC JUDY JACKSON; DR. JOHN DOE; JANE DOE; JEFFREY BEARD; ASSIST. SUPER. WILLIAM BARR; MARILAND BROOKS,** **Defendants.**	**Civil Action No. 04-230-ERIE** **Judge Maurice B. Cohill, Jr.** **Mag. Judge Susan P. Baxter**

DECLARATION OF MARK BAKER, D.O.

I, Mark Baker, D.O., declare under penalty of perjury that the following is true and correct to the best of my knowledge and belief:

1. I am the Medical Director at SCI-Albion, and I have held that position since the inception of the facility, in or about 1993. I am employed by Prison Health Services, Inc.

2. With respect to the care and treatment of individual inmates, my duties as Medical Director include, among other things, participating in direct patient care and overseeing the care provided by physician's assistants.

3. I am familiar with inmate DeFranco and have examined and treated him on numerous occasions. His ongoing or chronic medical problems as reflected in his chart have included mitral valve prolapse. However, an echochardiogram which could have diagnosed this condition was non-diagnostic in 2004. The angina that DeFranco

experiences is nontypical angina pectoris, which is correlated with anxiety, not actual cardiac chest pain.

4. DeFranco's complaints of chest pain are noted in his medical chart from SCI-Pittsburgh and were also attributed to anxiety. He had a stress test while at Pittsburgh in 1997 with negative results. He also had an Echocardiogram in May 1996 which showed only trace bicuspid regurgitation – clinically insignificant. He had a repeat EKG at Albion in May 2003 that was clinically insignificant.

5. In June 2003, I prescribed aspirin and under the tongue Nitroglycerin, as needed only, for his atypical chest pain. I also ordered another Echocardiogram (1/27/04) which reflected no definitive evidence of mitral valve prolapse, mitral stenosis or obstructive cardiomyopathy and only trace mitral insufficiency.

6. I understand that inmate DeFranco maintains that his heart condition is aggravated by the anxiety he experiences when double celled. I disagree.

7. The medical department does not actually vote on Z-code classifications (although psychology does). However, if an inmate has a serious medical condition which I believe would be relevant to his classification, I would inform staff involved in the Z-code review. As inmate DeFranco does not have such a condition warranting single cell status, I have never consulted with staff on that issue. In fact, it would be better for DeFranco, with his minor heart condition, to have a cellmate.

I declare under penalty of perjury that the foregoing is true and correct, per 28 U.S.C. § 1746.

Date: August 1, 2006

Mark Baker, D.O.

CONSULTATION RECORD

Part A: Completed by referring facility:	Type of Consult: (Circle) Initial Follow-up On-Site Off-site Telemedicine (circled: Initial, On-Site)	
Referred to: Main Medical Dr.	Referred by: Dr. Mark Baker Medical Director	Appt. Date/Time: ~~11/03~~ 1/04
Specialty: U/Vascular	Drug Sensitivity: NKA	Copies of relevant health information attached: (circle) Yes No

Reason for Referral/History of Present Illness/Injury:

– for Dupplicator Funda –

Echocardiogram re: Chest pain – [illegible]; EKG + E
(Dam pain, [illegible]

[illegible] – mild mitral valve prolapse on 18' echocardiogram

Treatment to Date/Current Medications and Significant Medication History:

Mitral [illegible]: Lopressor [illegible]

Dr. Mark Baker
Medical Director

[signature] 12/[illegible]/03
Signature of Referring Physician Date

Reviewed by Medical Director: (Circle) Approval (circled) Disapproval Medical Director Signature: Date:	Forwarded to UR (Date):

UR Decision: (Circle) Approval Disapproval Date:

Part B: To be completed by consulting Physician and returned with officer to the facility:

11/20/03 - No Show on Visit – R/S for 12/03 Clinic / KC
R/S for 1/04 Clinic

Echo prelim: Trace mitral/tricuspid Regurg.
mild MVP

Keith [illegible] RDCS RVS
1/20/04

Signature of Medical Director Date/Time

Signature of Consulting Physician Date/Time

Consultation Record
Commonwealth of Pennsylvania
Department of Corrections
DC-441
(Revised: 6-02)

Inmate Name: DeFranco, Anthony

Inmate Number: CZ3518

DOB: [illegible]

Facility: Alb

KC

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2403 Sidney Street
Suite 220
Pittsburgh, PA 15203
(412) 390-0500 (302)
(412) 390-0400 fax
(412) 481-3760 tollfree

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ECHOCARDIOGRAPHY REPORT

SCI – Albion
Dr. Baker
10745 Route 18
Albion, PA 16475

C-3518

Patient Name: **Anthony De Franco** **SS #: CZ 3518**
Date of Birth: 12/23/63 **Sex:** Male **Phone Number:**
Date of Exam: 1/27/04 **Exam Location: SCI – Albion**
Technologist: Keith Ricketts **Tape # KR Echo/Vasc 04-1**

Indications: Chest pain, left arm pain, h/o mitral valve prolapse.

M-Mode/2-D Measurements

AoR - Diastole	**2.2** (2.0-3.7 cm)	LV - EDD	**4.2** (3.5-5.6 cm)
ACS	**1.8** (1.5-2.6 cm)	LV - ESD	**3.0** (2.5-4.1 cm)
LA Diameter - Systole	2.4 (1.9-4.0 cm)	Fractional Shortening	28 > 31%
Interventricular Septum – Diastole	.9 (0.7-1.1 cm)	LV Ejection Fraction	55-60 (>55%)
LV Posterior Wall – Diastole	.9 (0.7-1.1 cm)	MR trace MS no	AI no AS no

Qualitative Analysis: M-mode and 2-D –

Echocardiographic imaging is of adequate technical quality and demonstrates normal aortic root dimensions. The aortic valve is composed of 3 normal appearing cusps. There is no evidence of aortic stenosis or insufficiency. The left atrial size s normal. The mitral valve is structurally normal. There is no definitive evidence of mitral valve prolapse, mitral stenosis or obstructive cardiomyopathy. The anterior leaflet demonstrates a mild degree of late systolic hammocking that does not meet diagnostic criteria for MVP. Trace mitral insufficiency is evident. Left ventricular size, wall thickness and contractility appear normal. The LVEF is visually estimated to be approximately 55 to 60%. No regional wall motion abnormalities are identified. The atrial septum is intact. Right atrial size is normal. The tricuspid valve is structurally normally. Trace tricuspid insufficiency is present without evidence of pulmonary hypertension. Right ventricular size and contractility appear normal. There is no pericardial effusion. No intracardiac thrombi, masses or vegetation is noted.

CONTINUED

Dr. Mark Baker
Medical Director

Diagnostic Stamp
Practitioner
Date 1-30-04
Time 1035

A	N	NCS
Abnormal (Requires A DC-472 Soap Note)	Normal	Not Clinically Significant

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INTERPRETATIONS:

1. **Minimal systolic hammocking of the anterior leaflet of the mitral valve without echocardiographic features that are diagnostic of mitral valve prolapse.**
2. **Trace mitral insufficiency.**
3. **Normal left atrial size.**
4. **Normal left ventricular size and contractility. LVEF approximately 55 to 60%.**
5. **Trace tricuspid insufficiency without evidence of pulmonary hypertension.**
6. **No prior study available for comparison.**

Charles M. Crispino, MD, FACC

CMC/ld
D: 1/28/04
T: 1/28/04

Diagnostic Stamp
Practitioner
Date 1-30-04
Time 1633

A	N	NCS
Abnormal (Requires A DC-472 Soap Note)	Normal	Not Clinically Significant

Dr. Mark Baker
Medical Director